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Letters to the Editor

Response to "Kanchan and Menezes, Double human bite – A different perspective" [*J Forensic Legal Med* 2009;16:297]

Sir,

I have read Drs Kanchan and Menezes' letter [1] rejecting my proposed sequential mechanism of injury in my original case report. [2]

I have reviewed my contemporaneous case notes and I do not agree either with their hypothesis or conclusions in this case; indeed finding their before-and-after reversed arrow marks on my original photograph facile, unconvincing and superfluous.

I think that it is indeed quite possible that the chicken may come before the egg in other such cases, however its relevance to an interesting pair of bite marks, or whether this adds anything to this, as far as I know unique, *vignette* of confirmed concentric bite marks must remain forever conjectural.

I am also intrigued that this case has come to their attention four years after the date of publication of my original report and I am left wondering what their point is.

Conflict of Interest

None declared.

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1. Kanchan T, Menezes R. Double human bite – a different perspective. *J Forensic Legal Med* 2009;**16**:297.
2. Bruce-Chwatt R. Double human bite. *J Clin Forensic Med* 2005;**12**:277.

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Male forensic physicians have an important role in sexual assault care. 'A response to "Chowdhury-Hawkins et al. Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs)" [*J. Forensic Legal Med.* 15 (2008) 363–367]'

Sir,

The study of Chowdhury-Hawkins and colleagues, published in the August 2008 issue of the *Journal*[1] has a number of methodological flaws which we believe invalidate their conclusion that most Sexual Assault Referral Centre (SARC) attendees have a preference for female staff. Of particular note was their finding of an overwhelming preference for a female physician among female victims. In contrast to UK guidelines referred to by Chowdhury-Hawkins et al.[1] in Australia a more liberal attitude is taken to male doctors working in SARCs. In fact, 13% of the membership of Forensic and Medical Sexual Assault Clinicians Australia, the national peak professional body in this field, comprises male forensic physicians. Our collective experience is that female victims may voice concerns regarding a male forensic examiner prior to the examination, but following comprehensive and sensitive medical care by a male doctor they invariably report their experience to be a positive one.

A comparison of British SARC attendance statistics with large population-based samples[2,3] provides an interesting insight into possible consequences of a SARC policy strongly recommending female over male staff. In England and Wales, among over 22,000 participants, 24% of women and 5% of men report a lifetime history of sexual assault.[2] These estimates are strikingly similar to those reported in the Australian Study of Health and Relationships.[4] The most recent British Crime Survey of almost 24,000 respondents from England and Wales estimates that actual or attempted sexual assault is experienced annually by 0.6% of men and 3.1% of women.[3] Thus, approximately one-sixth of British adults who have ever been sexually assaulted are men, and over 16% of British adults experiencing sexual violence each year are men. In contrast, only 5.1% of Chowdhury-Hawkins and colleagues' sample were men, a figure in keeping with a previous publication from the Haven in London which reported that only 6% of almost 700 SARC attendees were men.[5] Such male SARC attendance figures are substantially lower than those expected from more rigorous British population-based statistics. Perhaps these data point to a crucial problem with UK SARC policy: that perpetuating a female staff environment actually discourages male victims from attending acute medical/forensic sexual assault services.

Australian data from 2001/2002 support this assertion. Men account for an average 8% of acute presentations to SARCs in major Australian cities.[6] At this time, the largest sexual assault service in Sydney, the Eastern and Central Sexual Assault Service (ECSAS), employed four male staff members, including three of ten forensic physicians (one employed as the Medical Coordinator) and a male psychologist employed as the Deputy Manager. It is unsurprising

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then, that 14% of all presentations to ECSAS were men and ECSAS saw almost 40% more male victims than any other Australian SARC.[6] Such figures lend weight to our argument that employing SARC staff of both genders could improve attendance rates among male victims.

We agree that all individuals having intimate examinations, including sexual assault victims, should ideally be offered a choice of examining doctor's gender. Irrespective of the health issue under study, patients' ability to choose their physician is a key determinant of satisfaction with health care.[7] However, due to a shortage of willing, experienced and properly qualified forensic physicians and an over-stretched public health system in many countries, such choice is often impossible. Cultural issues may dictate the gender of examining physician for many individuals, irrespective of gender. This is the case for most genital examinations, not just those involving sexual assault victims.[8] We believe that most physicians would defer an examination in such circumstances. However, in time-dependent situations such as the forensic examination, deferral may not be an option. An alternative, often employed by Australian male forensic physicians, is the offer of a female chaperone. Such a strategy is relatively popular among female sexual health centre attendees when the examining clinician is male.[9]

We dispute the authors' statement that "victims do not want to be intimately examined by a male doctor soon after the event" and their suggestion of a "strong likelihood" that care by a male forensic physician will be refused by female victims. The three male authors have provided acute sexual assault care to an estimated 3000 female and male victims over a combined 50 years providing forensic and medical sexual assault care. Our collective experience is that examination of female victims by a skilled and empathetic male physician is not only acceptable to the majority of victims, but that many female victims subsequently report such an experience as a positive one. Indeed, Chowdhury-Hawkins and colleagues provide some evidence of this stance from one study respondent who commented that "an individual's attitude is important regardless of their gender". The authors reference three publications to support their introductory statement that both female and male victims prefer female staff caring for them following sexual assault. Despite extensive searches, we were only able to obtain one of these papers; that of Kelly and colleagues.[10] This paper, while noting that choice of clinician gender is desirable, considers this only one component of comprehensive sexual assault management. Kelly et al.[10] do not, in fact, provide empirical evidence that sexual assault victims of either gender prefer care by female staff. Ironically, their views concur with our own: that it is the skills and empathy of the clinician rather than gender that is the crucial element in providing quality sexual assault forensic care.[10]

The fatal flaw in Chowdhury-Hawkins and colleagues' study is their failure to include any respondents who had experienced acute sexual assault care by a male forensic physician or male counsellor. Enrolment solely by female SARC staff is also likely to have influenced study results. We have no doubt that the standard of care provided by female SARC employees in the UK is of a high standard. However, victims' responses will undoubtedly be influenced by a positive experience with female staff. Such a highly selected study base introduces irreparable selection bias, as does the lack of response from almost 80% of SARC attendees despite substantial efforts by the authors to encourage participation. The results may have been far different should a number of respondents have received excellent quality care from male forensic physicians and/or counsellors.

To determine the generalisability of study findings, it would have been useful had the authors included data regarding differences between respondents and non-respondents. This could have been achieved by data linkage between surveys and medical files. It is unclear how many male victims presented to the three SARCs during the study period, or if the nine (5.1%) male participants represented a similar proportion to the overall male presentations at these three centres. In addition, measurement bias cannot be excluded as no details were provided on the wording of gender preference questions in the survey instrument.

Recruitment of SARC forensic physicians is notoriously difficult[11] and our collective experience is that this is an ongoing problem. A strategy in UK SARCs which discourages employment of interested, committed and, ultimately, skilled male doctors will further compound this problem. SARCs in five of Australia's seven state/territory capitals currently employ male forensic physicians. We strongly believe that a mixed gender staff employment strategy in SARCs is the best approach to ensure adequate and high quality medical staffing of SARC after-hours rosters. The Australian experience suggests that although reservations may exist regarding the gender of the examining doctor prior to examination, both female and male victims report similar positive outcomes regardless of forensic physician gender. We challenge Chowdhury-Hawkins and colleagues' assertion that most SARC clients want to see female staff, primarily as this conclusion is based on an unacceptably biased study from which no such inference is able to be drawn.

Conflict of Interest

None declared.

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